State of New Jersey
DEPARTMENT OF HEALTH
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SHEREEF M. ELNAHAL, MD, MBA
Acting Commissioner

March 26, 2018

VIA Electronic mail: darlenetranquilli@gmail.com,
Certified Mail, RRR, UPS Next Day Air,
and Regular Mail

Darlene Tranquilli, Owner/Administrator
Selah Care Center
131/133 Fourth Street
Belvidere, New Jersey 07823

RE: NOTICE OF SUMMARY SUSPENSION OF SELAH CARE CENTER DEMENTIA CARE HOME LICENSE

Dear Ms. Tranquilli:

In accordance with the provisions set forth at N.J.S.A. 26:2H-14 and N.J.A.C. 8:43E-3.8(a), Selah Care Center is hereby NOTIFIED that its license to operate as a dementia care home is hereby SUMMARILY SUSPENDED. Accordingly, Selah Care Center shall immediately CEASE AND DESIST providing services under its dementia care home license.

The Dementia Care Home Act ("the Act"), N.J.S.A. 26:2H-148 et seq., and N.J.S.A. 55:13B-5.1 (P.L. 2015, c. 125), transferred responsibility for the licensing of dementia care homes from the Department of Community Affairs to the Department of Health ("Department"), effective June 2, 2016. Pursuant to the Act, the Department is "empowered to exercise such authority with respect to a dementia care home as the department is granted with respect to any other health care facility licensed by the department." N.J.S.A. 26:2H-149(a)(2). The Act also provides that the Department is "responsible for licensure, inspections, and the establishment and enforcement of standards with respect to each community residential facility in the State that provides services to residents with

special needs, including, but not limited to, persons with Alzheimer's disease and related disorders or other forms of dementia, which shall hereafter be known as a dementia care home." N.J.S.A. 26:2H-149(a)(1). In furtherance of each of the aforementioned statutory objectives, the Department adopted rules that govern the licensure and inspection of dementia care homes as well as the enforcement actions that the Department may take against a domestic care home that is in violation of the Department's rules. Those rules are set forth in their entirety at N.J.A.C. 8:37-1.1 et seq. and N.J.A.C. 8:34E-1.1 et seq.

After conducting surveys of Selah Care Center ("Selah") on October 26, 2016, November 14, 2017 and January 31, 2018, the Department found licensure violations that posed a serious risk of harm to the health, safety and welfare of Selah's residents. Despite the fact that Selah was repeatedly issued deficiency notices for the serious violations found within the facility, Selah failed to come into compliance with the Department's licensure rules. As a result, the Department issued a Notice of Revocation of Licensure to Selah on February 21, 2018. The survey deficiency reports dated October 26, 2016, November 14, 2017 and January 31, 2018 as well as the revocation notice are enclosed herewith and incorporated herein by reference.

After issuing the notice of revocation, Department staff visited Selah on March 6, 2018 to conduct a monitoring survey. The March 6, 2018 deficiency report is enclosed herewith and incorporated herein by reference. From the visit, the Department learned that the facility remained out of compliance with the licensure rules and further discovered the existence of harmful and dangerous conditions at the facility. Specifically, the visit revealed that the facility did not have at least two staff persons on duty at all times, in violation of N.J.A.C. 8:37-5.3. This deficiency created an immediate jeopardy (IJ) situation for the residents because without sufficient staff there was no way for the facility to provide necessary care to the residents and ensure their safety. Indeed, all of Selah's residents suffer from dementia and require moderate to extensive assistance from staff for their activities of daily living as well as assistance to exit the building during an emergency, such as a fire. Thus, Selah's lack of adequate staffing placed the residents in harm's way. The surveyors also discovered that the facility left the medication cart unlocked and unattended and left a significant amount of pre-poured medications unattended in a resident's room in violation of N.J.A.C. 8:37-6.3. This deficiency also created an IJ situation due to the fact that the residents of Selah are cognitively impaired and could easily have ingested copious amounts of the unattended medications to their detriment. In fact, with the facility's inadequate staffing to oversee the residents' movement and actions, there was an enhanced risk that residents could consume these unattended medications in fatal amounts. And, equally disturbing, Selah staff impeded the survey by refusing to respond to questions posed by the Department's surveyors and telling the surveyors they had to leave the facility. Due to Selah's refusal to fully cooperate with the survey, in violation of N.J.A.C. 8:37-2.4, the Department had no way to ensure that additional IJ violations did not exist in the facility.

Due to the serious violations found on March 6, 2018, the Department staff visited Selah on March 13, 2018 to conduct another monitoring survey. The March 13, 2018 deficiency report is enclosed herewith and incorporated herein by reference. The surveyors found additional harmful and dangerous conditions at the facility and discovered that some of the serious violations that were exposed during the March 6th visit were not corrected. Specifically, the surveyor discovered that the facility remained out of compliance with the Department's staffing requirements, which continued to pose a serious threat to the residents' health and safety. Furthermore, the surveyor observed nine portable space heaters throughout the facility with six actively running and three plugged in but not turned on, in violation of N.J.A.C. 8:37-7.6. The surveyor further found that the residents were not only unable to self-evacuate in an emergency, due to physical and mental limitations, but were also unable to move out of their own beds because they are equipped with side rails that cannot be lowered by the residents themselves. In fact, the administrator had a difficult time lowering the bed rails when demonstrating their use to the surveyor. This created an IJ situation for the residents because the lack of adequate staffing would prevent the facility from evacuating the residents in a timely manner in the event of an emergency, such as if the prohibited space heaters caused a fire, which would result in serious injury or death to the residents. The surveyor also found harmful chemicals and liquids, including dog medication and Lysol, in numerous unlocked areas of the facility that were readily accessible by residents, in violation of N.J.A.C. 8:37-7.7. This deficiency also created an IJ situation because the residents of Selah are cognitively impaired and could easily have ingested these unlocked chemicals.

Given the egregious violations found on March 6th and March 13th, Department staff visited Selah again on March 20, 2018 to conduct a monitoring survey. The March 20, 2018 deficiency report is enclosed herewith and incorporated herein by reference. This visit revealed that the facility continued to place its residents at serious risk of harm. Specifically, the facility still did not correct the IJ situation posed by its failure to have adequate staff on duty at all times, which posed a serious threat to the residents' health and safety. Again, the residents at the facility are unable to self-evacuate, and without adequate staff there was no way for the facility to evacuate its residents in a timely manner in order to prevent serious injury to or death of the residents during an emergency. Moreover, the administrator advised that the facility's registered nurse resigned and, as a result, the facility did not have a nurse. Because the facility did not retain a nurse, its certified medication aide was prohibited from dispensing medication to the facility's residents, pursuant to N.J.A.C. 8:37-6.2 and N.J.A.C. 13:37-6.2. As such, each resident's health was placed in immediate jeopardy as a result of the facility's failure to maintain a nurse on staff.

Unfortunately, as of March 24, 2018, the facility remained out of compliance with the Department's rules, as a monitoring survey that was

conducted on this date showed that the facility still did not have a nurse on staff to oversee the administration of medications to the residents.

Based upon the foregoing, the Department has determined that Selah's license as a dementia care home must be summarily suspended. Pursuant to N.J.A.C. 8:43E-3.8, "the Commissioner may order the summary suspension of a license of a health care facility . . . upon a finding that violations pertaining to the care of patients or to the hazardous or unsafe conditions of the physical structure pose an immediate threat to the health, safety, and welfare of the public or the residents of the facility." See also N.J.S.A. 26:2H-14. In the present matter, the Department provided Selah with a significant amount of time to come into compliance with the dementia care home licensing rules, but it has failed to do so. In fact, the above cited deficiencies demonstrate a serious disregard for and a consistent failure by Selah to comply with the Department's rules. Even more, the continuous violations found by the Department's survey staff, as explained above, pose an immediate and serious threat to the health, safety and welfare of the facility's residents. As such, the Department finds that Selah's continued licensure as a dementia care home constitutes an immediate and serious threat to the health, safety and welfare of its residents. **Therefore, Selah's license as a Dementia Care Home is immediately suspended.**

Accordingly, **Selah has until the close of business on Thursday, March 29, 2018 to relocate its remaining residents to appropriate long-term care facilities.** Failure to comply with this Notice of Summary Suspension will result in additional enforcement action initiated by the Department against Selah, including but not limited to monetary penalties and a court action for the appointment of a temporary manager, at Selah's expense, to arrange for the relocation of the residents.

Pursuant to N.J.S.A. 26:2H-14 and N.J.A.C. 8:43E-3.8(e), Selah has the right to request a hearing, in writing, within forty-eight (48) hours from the receipt of this Notice of Summary Suspension, to the following address:

Joy Lindo, Director
Office of Legal and Regulatory Compliance
New Jersey Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360

Failure to do so shall constitute a waiver of the right to hearing.

Should you have questions concerning this Notice of Summary Suspension of License, you may contact me at (609) 984-8128 or you may contact Lisa King of my staff, at (609) 984-8161. On all correspondence related to this matter, please refer to Control# X 18008.

Sincerely,

Gene Rosenblum, Director
Program Compliance & Health Care Financing
Program Compliance and Health Care Financing
Division of Certificate of Need and Licensing

cc: Stefanie Mozgai
Control # X 18008